**Benefit Choice Enrollment: May 1-31**

The Benefit Choice Enrollment Period will run Friday, May 1, through Sunday, May 31. During this time, you may enroll in the flexible spending accounts and make changes in your current health, dental and life insurance coverages with changes effective July 1. In campus mail you will receive the State of Illinois Benefit Choice booklet and also a letter and enrollment worksheet from the Benefits Center. Faculty and staff members participating in either of the flexible spending accounts – Medical Care Assistance Plan or Dependent Care Assistance Plan – will be sent re-enrollment forms to their home address by the Department of Central Management Services.

There are three different methods available to make changes in your state of Illinois benefits. You can use the telephone enrollment system (see Page 7), a university Web-based application called NESSIE, or an enrollment worksheet (that you should receive in campus mail) to be returned to the Benefits Center. Employees may access the NESSIE system (Net-driven Employee Self-Service Information Environment) at http://nessie.uihr.uillinois.edu. The enrollment application may be found in the “Your Benefits” section of the site. The system may be used to make changes until midnight Sunday, May 31. If you decide not to make any changes, no action on your part is necessary. Your present enrollment will remain in effect until the close of business on Thursday, May 28, unless you receive information from your HMO detailing its benefit changes for the upcoming plan year. A copy of this documentation should be returned to the Benefits Center.

**Don’t be late! (Irrevocability rule)**

Any changes that you want to make during the Benefit Choice enrollment period must be submitted May 1 through May 31. The last day you can personally deliver forms to the Benefits Center is Friday, May 29. If you walk in with a form on Monday morning, June 1, your form cannot be accepted. We are permitted to accept changes sent through the U.S. Postal Service (USPS) if postmarked on or before May 31. For example, assume the Benefits Center receives two forms on Tuesday, June 2, 1998 – one by campus mail and the other by the USPS. Regardless of when the form received in campus mail was signed and sent, the Benefits Center cannot accept it. However, if the form sent by USPS was postmarked on or before May 31, the Benefits Center can accept it.

Also, remember that both the state’s telephone enrollment system and NESSIE can be used to make changes until midnight on Sunday, May 31. The reason for the inflexibility in these deadlines is the State of Illinois Premium Payment Plan. Under this plan, payroll-deducted premiums members pay for health, dental and life coverage are tax exempt. The Internal Revenue Service code requires plans with the tax-exempt premium to prohibit changes in the member’s deduction during the plan year unless there is a qualified change in family status, special enrollment period or other special circumstances. This Irrevocability Rule is required pursuant to Section 125 of the Internal Revenue Code. If the state is not in compliance (accepts forms late), the plan could lose its qualification and/or employees could be subject to an IRS audit and be required to pay additional taxes and possible penalties.

### Member benefit information

Last year CMS published a new state of Illinois Benefits Handbook (effective July 1, 1997 – June 30, 2000) which was distributed to employees in campus mail fall 1997. Please keep that handbook and the new Benefit Choice Options booklet (effective July 1, 1998 – June 30, 1999,) along with this newspaper. Together, these items should provide all the relevant information you need regarding state plan benefits. You will receive a new Benefit Choice Options booklet next year. Employees enrolled in an HMO also should receive information from their HMO detailing its benefit changes for the upcoming plan year.

For information on additional benefits such as vacation and sick leave, refer to the Employee Benefits Chart in the Campus Administrative Manual, Section IV/A-7 (www.uiuc.edu/admin_manual/cam/section_4.html) or the Academic Benefits and Services Guide in the Academic Staff Handbook (www.oc.uiuc.edu/ahr/handbook).

## What You Can Change

<table>
<thead>
<tr>
<th>Change</th>
<th>What You’ll Need</th>
<th>Telephone Enrollment?</th>
<th>NESSIE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switch health plans – from an HMO to the Quality Care Health Plan or vice versa, or from one HMO to another.</td>
<td>Enrollment worksheet. Additional form may be required by HMOs outside U.C. Contact Benefits Center.</td>
<td>Yes (page 7)</td>
<td>Yes</td>
</tr>
<tr>
<td>Add dependents to a health plan (automatically enrolls dependent for dental and vision plans). See page 5.</td>
<td>Enrollment worksheet.</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Drop dependents from health, dental and vision plans.</td>
<td>Enrollment worksheet.</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Switch dental plans – from Quality Care Dental Plan to the managed-care plan or vice versa.</td>
<td>Enrollment worksheet: managed care plan requires participating dental office name and number. Yes (page 7)</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Increase state plan life insurance.</td>
<td>Enrollment worksheet and statement of health from the Benefits Center, insurance company approval required.</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Decrease state plan life insurance.</td>
<td>Enrollment worksheet.</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Enroll in Medical and/or Dependent Care Assistance Plans. See page 5. Re-enrollment required each year.</td>
<td>Enrollment form included with the plan brochure available from the Benefits Center; for re-enrollment, you must use the enrollment form sent to your home by CMS or the enrollment form from the brochure.</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

**Make your changes through May 31**

**SURS Retirement Options**

Beginning July 1, State Universities Retirement System (SURS) participants may choose from three retirement options. Current SURS participants, who are eligible for retirement on July 1, may elect to remain with the Traditional Benefit Package or move to the Portable Benefit Package. New SURS options:

- **SURS Traditional Benefit Package** maintains the same benefit and contribution provisions that existed before the new legislation.
- **SURS Portable Benefit Package** is much like the existing SURS Traditional Benefit Package but provides a more generous account balance refund if you terminate your employment and move elsewhere.
- **SURS Self-Managed Plan** establishes an account in your name into which both employee and employer contributions will flow; you decide how your account balance will be invested, selecting from among a variety of mutual funds and other investment options for that purpose.

SURS will begin accepting participant elections on July 1. All current employees will have until June 30, 1999, to notify SURS of their retirement plan choice. Employees hired after the July 1 date will have 60 days to make a decision.

Once you choose a retirement option, your decision is irrevocable; it cannot be changed. Because this decision is important, SURS is providing a comprehensive education program to help you evaluate your particular circumstances. To help you make the best decision, you are encouraged to take advantage of the education information that is made available, including:

- **Choice Package**
  - This package includes a workbook, Individual Summary Statement, Choice Summary brochure, and a Choice Election form. For those selecting the Self-Managed plan, additional materials will be sent from the three service providers: Aetna, ICMA and TIAA-CREF.
- **Campus Presentations**
  - SURS will sponsor several general information presentations. In addition, there will be meetings hosted by representatives from the Self-Managed Plan service providers – Aetna, ICMA and TIAA-CREF. These presentations will include information specific to each company’s investment alternatives. Scheduled presentations are listed on Page 7. These are approved events for Civil Service employees. Employees may be released from work with pay, operations permitting and with departmental approval, to attend one of each of these optional retirement plan meetings. The approved time with pay may be combined with the lunch break if requested by the employee.
  - Additional sources of information include the SURS newsletter, SURS counselors at (800) ASK SURS. The SUERS Newsletter Advocate, as well as the following Internet sites: SURS at http://www.surs.com, ICMA Retirement Corp. at http://www.icmarg.org, TIAA-CREF at http://www.tiaa-cref.org/ilinois/ and Aetna at http://www.aetna.com/ilsmpy,
Medical claims
UNICARE is the claims administrator for the Quality Care Health Plan. Central Management Services (CMS) has instituted a change in UNICARE’s standard claims processing procedure. After a claim is initially processed, payment to the member or provider is normally expected to occur within six to eight weeks. Previously, CMS instructed the claims administrator to send the member’s Explanation of Benefits (EOB) form at the same time the payment was sent. Now, the EOB is sent to the member when the claim is initially processed but the payment to the member or provider will be sent within six to eight weeks later.

Claims should be filed promptly; however, the plan requires that all claims (medical, pharmacy and mental health/substance abuse treatment) must be filed no more than two years from the ending date of the plan year in which the charge was incurred.

Service date of claim
Prior to July 1, 1996
June 30, 1998
July 1, 1996–June 30, 1997
June 30, 1999
July 1, 1997–June 30, 1998
June 30, 2000
Claims should be submitted to:
UNICARE, State of Illinois
Group Number 28455
P.O. Box 5025
Bolingbrook, IL 60440-5025

When is precertification required?
- Non-emergency hospital admission.
- Elective surgery (at least seven days prior to any elective surgery).
- Maternity hospital admission. (See Benefits Handbook.)
- Admission to nursing home or extended care facility/hospital.
- Coverage when Medicare Part A inpatient benefits are exhausted.
- Notification is required within two business days of an emergency hospital admission.

The penalty for failure to precertify is $400. Call (800) 327-7443.

Prescription claims
National Prescription Administrators Inc. (NPA) is the claims administrator for pharmacy coverage in the Quality Care Health Plan. New members will receive “welcome” packets with cards that contain NPA’s address and telephone number as well as information to assist pharmacies in transmitting a claim electronically. It is expected that one card will be sent to each member, two cards will be provided for those with one or more dependents. The initial card(s) issued by NPA will be free; however, each replacement card costs $10.

Members should identify themselves as Quality Care Health Plan members at the pharmacy so their claims can be submitted electronically. If a paper claim form is needed, members should call NPA at (800) 250-9594 and a form will be mailed to them. Claims should be submitted to:
NPA, Group Number 1400
711 Ridgedale Avenue
East Hanover, NJ 07936

The co-pay ($6 for generic medicines and $12 for brand names) applies to each 30-day supply.

Reimbursement for out-of-network prescription purchases will be limited to the network price less the applicable copayment. When a generic drug is available but a brand name is purchased for any reason, the member must pay the difference in cost between the brand-name drug and the generic drug plus the generic copayment of $6.

Mental health claims
Green Spring Health Service Inc. is the mental health and substance abuse administrator for QCHP. To qualify for the highest level of benefits with the lowest out-of-pocket costs, members must call (800) 513-2611 to receive pre-approval and a referral to a network provider. Additional details about the mental health and substance abuse benefits are included in the State of Illinois Benefits Handbook and in the Member Assistance Program Employee Information Guide, which is available from the Benefits Center.

Claims appeal process
Information about the claims appeal process for QCHP is provided on Page 35 of the Benefits Handbook.

Usual and Customary (U&C)
For network Preferred Provider Organizations (PPO) charges, Usual and Customary (U&C) is an amount determined by the plan administrator according to the negotiated fee schedule for that provider or product.

For non-network or Non-Preferred Provider charges, (U&C) is an amount determined by the plan administrator not to exceed the general level of charges being made by providers in the locality where the charge is incurred when furnishing like or similar services, treatment, or supplies for a similar medical condition.

If the charges exceed usual and customary, you are responsible for the portion of the expense that is above the usual and customary. Amounts in excess of usual and customary are not eligible charges and are not applicable to annual plan deductible or out-of-pocket maximum.

IMPORTANCE: The percentage of the claim that will be paid is always based on the usual and customary charge or the actual charge made by the provider, whichever is less.

PPO hospital reduces your cost
Preferred Provider Organization (PPO) hospitals are those that the state has contracted to provide services at a negotiated rate. In Chicago-Aurora, both Carle and Provena Covenant are PPO hospitals. There are also PPO hospitals in most areas of the state, including facilities for inpatient treatment of alcoholism and substance abuse and transplant PPO facilities serving the state of Illinois. A complete list of facilities is included in the Benefit Choice Options booklet.

Out-of-pocket maximums

All stays in a PPO facility must be precertified. The advantages of using a PPO hospital:
- $100 hospital admission deductible is waived.
- Patient copayment is limited to 10 percent of eligible charges.

If the employee resides within 25 miles of a PPO hospital but chooses another hospital, the $100 deductible applies and the copayment increases to 35 percent. If there is no PPO hospital within 25 miles, the deductible still applies but the copayment is limited to 20 percent.

Out-of-pocket maximums
The separate non-PPO maximums are intended as an added incentive to avoid use of non-PPO facilities. When an employee chooses a non-PPO facility, his/her out-of-pocket maximum for deductibles and copays can be as much as $3,800 in eligible expenses; use of a PPO hospital limits the out-of-pocket maximum to $800 in eligible expenses (except for prescription drug or mental health or substance abuse service copayments which cannot be applied toward the out-of-pocket maximums). A summary of expenses that will apply toward the general and non-PPO out-of-pocket maximums can be found in the chart below.

What does ‘family cap’ mean?
Once the combined deductibles paid for your family members total the cap amount, no other family member need meet a deductible. For example, if your salary is $48,900 or less, and three family members satisfy their deductibles, the fourth will not have to satisfy a deductible before more benefits can be paid. A family cap of $300 does not mean that you must accumulate $300 in deductibles before any benefits can be paid; if one dependent satisfies his/her deductible, that dependent’s expenses will be paid without regard to a deductible.

Health Maintenance Organizations (HMOs)

HMOs and emergencies
A good rule of thumb is always to call your HMO before seeking emergency medical care, either in or outside your HMO’s service area. If the emergency occurs in your HMO area and you are able, you should first try to contact your primary-care physician for instructions. If the emergency is after hours or you are out of the area, you should call the number provided on all HMO identification cards for that purpose. If the emergency is such that you are unable to call first, call as soon as possible after treatment is received. Making that call should eliminate the risk of claim problems when your HMO is asked to pay emergency charges.

Remember that the only out-of-area benefits available under an HMO are for emergency treatment or for non-emergencies when a referral has been issued by the HMO. This restriction is particularly important when you are traveling for an extended period or you have a dependent who is away, such as a child at school. For more information about how your HMO defines an emergency and what is required, if you have an out-of-area emergency, contact your HMO.

HMO claims appeals process
Most HMO problems can be resolved on an informal basis through the primary-care physician, or clinic or hospital administration personnel. However, if you feel a problem has not been resolved satisfactorily, there are additional appeal steps that can be used. Each HMO has its own three- to four-step complaint or grievance procedure that is detailed in the certificate provided to its members. Typically, at the highest appeal level the compliant status is/his/her case before a committee made up of other HMO members. The decision of that committee is binding upon the HMO.

If you are not satisfied with the final appeal, a complaint may be filed with the Illinois Department of Insurance and finally with the Group Insurance Division of Central Management Services. “Final” appeal information is included in the Member Benefits Handbook.

Remember to precertify all inpatient and surgical care and save $400. Call (800) 327-7443.
<table>
<thead>
<tr>
<th>Comparison of Health Plans</th>
<th>Quality Care Health Plan <em>(administered by UNICARE)</em></th>
<th>HMO plans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Benefits payable subject to usual and customary (U&amp;C) limitations. Consult Member Benefits Handbook, Pages 37 to 63, for complete benefits information.</td>
<td>These are the minimum benefits HMOs provide; consult HMO certificate for complete information.</td>
</tr>
<tr>
<td>General deductibles</td>
<td>$100 per non-PPO hospital admission $100 per emergency room Annual-plan deductible for all other charges (e.g., professional charges):</td>
<td>$100 per hospital admission $50 or 50 percent of emergency room charges, whichever is less</td>
</tr>
<tr>
<td></td>
<td>Employee</td>
<td>Annual salary</td>
</tr>
<tr>
<td></td>
<td>$48,900 or less</td>
<td>$150</td>
</tr>
<tr>
<td></td>
<td>$48,901-$61,200</td>
<td>$250</td>
</tr>
<tr>
<td></td>
<td>$61,201 and over</td>
<td>$300</td>
</tr>
<tr>
<td></td>
<td>Each covered dependent</td>
<td>$100</td>
</tr>
<tr>
<td></td>
<td>Retiree, annuitant or survivor</td>
<td>$100</td>
</tr>
<tr>
<td>Inpatient hospital services</td>
<td>PPO hospital* 90 percent, no deductible</td>
<td>100 percent, after deductible</td>
</tr>
<tr>
<td>Semi-private, board, and nursing and ancillary services</td>
<td>See complete list of participating hospitals in the Benefit Choice Options Booklet, Pages 26-29. Non-PPO hospital 65 percent after deductible if member resides within 25 miles of PPO Increases annual out-of-pocket maximum. 80 percent after deductible if member does not reside within 25 miles of PPO. Note: All inpatient hospital confinements, including pregnancy/maternity, must be precertified to be eligible for full benefits. See below.</td>
<td>Hospital utilization admission review and surgery requirements vary. Consult specific HMO for details.</td>
</tr>
<tr>
<td>Mandatory precertification</td>
<td>Pre-certification of elective hospital admissions (including pregnancy) and surgery (including outpatient) is required. Emergency admissions require that certification be obtained within 2 business days of admission. Failure to obtain precertification will result in a $400 penalty. Call precertification unit at (800) 327-7443.</td>
<td>100 percent, after deductible</td>
</tr>
<tr>
<td>Second surgical opinion</td>
<td>100 percent, no deductible. Precertification will advise if second surgical opinion necessary.</td>
<td>100 percent</td>
</tr>
<tr>
<td>Extended-care facility</td>
<td>Pre-certification required; benefits are the same as described under Inpatient hospital services (above) when prescribed by a physician for medically necessary skilled care.</td>
<td>Benefits vary by HMO. Consult specific HMO for details.</td>
</tr>
<tr>
<td>Home health care</td>
<td>80 percent when alternative to inpatient hospitalization; precertification required.</td>
<td>100 percent</td>
</tr>
<tr>
<td>Hospice care</td>
<td>80 percent with physician's written certification of terminal condition; precertification required.</td>
<td>100 percent</td>
</tr>
<tr>
<td>Emergency room services</td>
<td>80 percent after $100 emergency room deductible</td>
<td>100 percent after the emergency room deductible</td>
</tr>
<tr>
<td>Physician and surgeon charges</td>
<td>80 percent after annual plan deductible</td>
<td>100 percent; $10 copayment per outpatient physician visit may apply</td>
</tr>
<tr>
<td>Durable medical equipment, prosthetic devices</td>
<td>80 percent after annual plan deductible</td>
<td>Prosthetic devices: 100 percent Consult specific HMO for limits</td>
</tr>
<tr>
<td>Outpatient diagnostic lab and X-ray</td>
<td>100 percent after annual plan deductible</td>
<td>100 percent</td>
</tr>
<tr>
<td>Preventive physician services, routine exams, child and well-baby care</td>
<td>Children through age 6, 80 percent, no deductible; Children entering grades 5 and 9, 80 percent, no deductible; Adults over age 18, 80 percent, no deductible, to $175 (combined physician/lab maximum)</td>
<td>$10 copayment per visit may apply, then 100 percent</td>
</tr>
<tr>
<td>Preventive (routine) lab, X-ray, immunization, screening tests</td>
<td>100 percent, no deductible; applies to children through age 6, children entering grades 5 and 9, and adults over age 18. Adult $175 limit (combined physician/laboratory maximum)</td>
<td>100 percent</td>
</tr>
<tr>
<td>Maximum out-of-pocket expense</td>
<td>After combined deductibles and copayments for eligible expenses equal $800 per individual per contract year or $2,000 per family per contract year, plan pays 100 percent of covered expenses for the remainder of the contract year. Use of non-PPO hospital will result in added out-of-pocket costs up to $3,000 per individual, $7,000 per family.</td>
<td>150 percent of total annual premium (combined member and state payments)</td>
</tr>
<tr>
<td>Annual maximums</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Lifetime maximums</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Free-standing benefits</td>
<td>Administrator: National Prescription Administrators (NPA)</td>
<td>Administrator: Green Springs Health Service (800) 513-2611 for referral</td>
</tr>
<tr>
<td></td>
<td>In-network, copay for 30-day supply</td>
<td>Inpatient: 100 percent coverage for up to 30 days for psychiatric admission; consult HMO for limits applicable to alcohol and substance abuse</td>
</tr>
<tr>
<td></td>
<td>$6 copayment for a generic drug</td>
<td>Outpatient: psychiatric care: 100 percent after $20 or 20 percent copayment per visit with a limit of 20 visits per contract year Alcohol- and substance-abuse: 100 percent; maximum number of visits determined by individual HMO.</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>$12 copayment for a name-brand drug with no generic equivalent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$6 plus difference between cost of name brand and generic if employee requests name brand when generic is available</td>
<td></td>
</tr>
<tr>
<td>Psychiatric care and alcohol- and substance-abuse care</td>
<td>Administrator: Green Springs Health Service (800) 513-2611 for referral</td>
<td>Administrator: Green Springs Health Service (800) 513-2611 for referral</td>
</tr>
<tr>
<td></td>
<td>Inpatient</td>
<td>Inpatient</td>
</tr>
<tr>
<td></td>
<td>In-network: $50 per day copayment up to $275 per admission then 100 percent</td>
<td>100 percent coverage for up to 30 days for psychiatric admission; consult HMO for limits applicable to alcohol and substance abuse</td>
</tr>
<tr>
<td></td>
<td>Out-of-network: $50 per day copayment up to $250 per admission then 90 percent</td>
<td>Outpatient: psychiatric care: 100 percent after $20 or 20 percent copayment per visit with a limit of 20 visits per contract year Alcohol- and substance-abuse: 100 percent; maximum number of visits determined by individual HMO.</td>
</tr>
<tr>
<td></td>
<td>Partial Hospitalization/Intensive Outpatient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In-network: $25 per day copayment up to $125 per admission then 100 percent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Out-of-network: $25 per day copayment up to $125 per admission then 90 percent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outpatient: if referral (in-network) through Member Assistance Program $15 copayment per visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If no referral (out-of-network)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychiatric care benefit will be 50 percent of charge, but not more than $35 per visit and no more than $50 visits per year; providers limited to licensed clinical social worker, psychologist or psychiatrist</td>
<td></td>
</tr>
</tbody>
</table>
Supplemental long-term disability insurance

Have you ever stopped to think what your source of income would be if you become disabled and unable to work for a period of months – or even years? While employees do have a 50 percent of salary disability income benefit through the State Universities Retirement System, it is generally not available during the first two years of employment and could be quickly exhausted by a person who has been employed for a relatively short time.

To fill potential gaps in coverage and provide an enhanced disability income benefit, the university has an optional long-term disability insurance plan, underwritten by Fortis Benefits, to supplement the SURS benefits.

Under the plan, the Fortis benefit and the SURS disability benefit will be coordinated so that a total benefit of 66 2/3 percent of basic pre-disability SURS benefits is available up to a maximum of $7,500 per month. Following are some examples of when this new plan would be beneficial.

1. An employee disabled in the first two years of employment who does not yet qualify for a SURS disability benefit – the Fortis plan would pay the full 66 2/3 percent of base salary.
2. An employee receiving the 50 percent benefit from SURS – the Fortis plan pays 16 2/3 percent of base salary so that the total disability benefit received is 66 2/3 percent of base salary.
3. An employee has exhausted the 50 percent SURS benefit but qualifies for the 35 percent disability retirement allowance – the Fortis plan pays 31 2/3 percent of base salary so that the benefit received continues to be 66 2/3 percent of base salary.

Watch for more information announcing the fall enrollment or contact the Benefits Center at any time for a brochure that provides details of the plan.

Are you saving for retirement?

Have you given any thought to how much your retirement income might be? Everything you read or hear about retirement tells you that you will need from 60 to 80 percent of your preretirement income as retirement income. Because many people are not with a single employer long enough to accumulate a pension at that level, having personal savings to supplement any pension and/or Social Security benefits becomes very important. Using tax-deferred retirement plans is an excellent way to build your own retirement savings – and save current income taxes, too.

The advantages of starting early

While it is never too late to start saving for retirement, there are strong advantages to starting early, even if you find you have to stop after a few years. Following are examples for two people, one starting at age 30 but stopping after 10 years; the other starting at age 45 and continuing to age 65. The example assumes monthly contributions of $100 and an annual growth/interest rate of 8 percent.

<table>
<thead>
<tr>
<th>Age</th>
<th>Start</th>
<th>Stop</th>
<th>Total</th>
<th>Accumulation at Age 65</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>0</td>
<td>10</td>
<td>$12,000</td>
<td>$133,099</td>
</tr>
<tr>
<td>45</td>
<td>0</td>
<td>20</td>
<td>$15,000</td>
<td>$266,902</td>
</tr>
</tbody>
</table>

Notice the person who only contributed for 10 years has $74,497 more at age 65 than the one starting at 45 and contributing for 20 years. This reflects the value of time and compounding of an investment. If the 30-year-old had continued to save at the same rate until age 65, the accumulation is even more dramatic – $229,388. It would take the employee starting at age 45 $685 per month to accumulate that same amount by age 65.

Save current income tax

In addition to future benefits, tax-deferred plans provide current tax saving through the use of tax-deferred investing by payroll deduction. That means dollars you otherwise would have paid in income taxes are working for you instead. The table below shows the tax savings realized at two salary levels. Each assumes zero exemptions claimed for tax purposes. Note that take-home pay actually doesn’t go down by the $100 invested. Consequently, many people find that they can actually afford to save more than they originally anticipated.

<table>
<thead>
<tr>
<th>Monthly Salary</th>
<th>2,083</th>
<th>4,167</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Take-home pay</td>
<td>1,581</td>
<td>3,165</td>
</tr>
<tr>
<td>Take-home pay saving</td>
<td>230</td>
<td>316</td>
</tr>
<tr>
<td>Annual tax savings</td>
<td>2,821</td>
<td>5,530</td>
</tr>
<tr>
<td>Annual tax savings</td>
<td>2,821</td>
<td>5,530</td>
</tr>
</tbody>
</table>

Life insurance

Optional plans

In addition to the employer-provided life insurance equal to 100 percent of your annual salary, you may purchase optional life insurance for yourself, your spouse and children under the state plan, subject to evidence of good health and insurance company approval. Health certificates are available from the Benefits Center and must be completed and returned by May 31. Also available is accidental death and dismemberment insurance, which does not require evidence of good health.

- State Plan Optional Life – 1, 2, 3 or 4 times annual contract salary.
  - Rate per $1,000 per month
  - Age of employee
  - Current rate
  - 24 or younger
  - 25 - 39
  - 40 - 44
  - 45 - 49
  - 50 - 54
  - 55 - 59
  - 60 - 64
  - 65 - 69
  - 70 - 74
  - 75 and above

- State Plan Spouse Life Insurance – $5,000.
  - Cost is $3.40 per month, regardless of age.

- State Plan Child Life Insurance – $5,000 per child.
  - Cost is $0.26 per month, regardless of number of children covered.

Who are your beneficiaries?

If there has been a change in your life – such as a marriage, divorce, death in the family, etc. – you should review your beneficiary designations on your life insurance. You may call to request copies of the latest designations you have on file be mailed to you. Or you may stop by the Benefits Center and look at your designations. You will have designated a beneficiary for the employer-provided state life insurance, which is equal to your annual salary. You also may have designations for accidental death and dismemberment insurance and tax-deferred annuity contributions. Changes in any of your beneficiary designations can be made at any time.

Remember that you also have a beneficiary designation on file at the State Universities Retirement System (SURS). The latest designation is printed in the SURS Personal Benefits Summary Statement distributed to employees in the fall every year or you can request a copy by calling SURS at 378-8800. The form required to change your SURS beneficiary can be obtained from either SURS or the Benefits Center.

Your Benefits • 4 • April 30, 1998
Vision care plan
The Vision Care Plan is provided to employees at no cost and automatically includes all employees and their dependents who are insured under one of the state health plans. It also extends to persons on disability, to retirees and to survivors.

Under the plan, which is administered by Vision Service Plan (VSP), employees and insured dependents are eligible for a standard eye exam and glasses once every 24 months. The plan benefits include:
- $10 patient copayment for an eye exam.
- $10 patient copayment for spectacle lenses, single or multifocal, glass or plastic (special options such as progressive, photochromic, tinted, etc., lenses must be purchased at an additional charge).
- $10 patient copayment for frames chosen from a selection of frames covered in full under the plan (frames not in the selection can be purchased at an additional charge).
- $50 patient copayment for elective contact lenses: hard or soft daily-wear lenses or rigid gas-permeable lenses. The contact lens benefits are for non-participating providers and for extended wear or disposable contact lenses is $70.

The most comprehensive benefits are provided when services are received from plan member doctors; however, benefits also are available for services received from non-member doctors. For a complete list of member doctors, call VSP at (800) 877-7195 or visit its Web site at www.vsp.com. When you go to a member doctor, you simply pay your copay amount and there is no paperwork. If you choose to go to a non-member doctor, for reimbursement from VSP, you must mail a copy of your bill to:
Vision Service Plan
222 South Riverside Plaza, Suite 2210
Chicago, IL 60606

More details about the plan, including benefits for non-member doctors, are in the plan brochure, which is available from the Benefits Center.

Previous users of VSP may receive repeat services on or after the first day of the 24th month following the initial service.

Flexible spending accounts
Do you have out-of-pocket medical or child-care expenses greater than $240 per year? You can save money by eliminating the tax you pay on the dollars used to pay these expenses by participating in the Medical Care Assistance Plan (MCAP) for medical expenses or the Dependent Care Assistance Plan (DCAP) for child-care expenses. The plans deduct from your paycheck – before tax is calculated – a minimum of $20 up to a maximum of $416.66 per month ($5,000 per year) that is deposited into an account in your name. When you have eligible expenses, you submit your receipts to the plan and are reimbursed with your untaxed dollars.

The amount of tax saved will vary depending upon marital status, your tax bracket and other factors. For example, assume you earn $30,000 per year and have expenses of $380 per month for child care. The tax savings on $300 would be approximately $75. Thus the child-care cost is reduced to $225 and you save $75. Out-of-pocket medical expenses, which can include deductibles and copayments for health care, vision, dental, hearing and prescription expenses, are usually lower, but setting aside even $20 per month results in a $7 per month tax savings.

If there is a negative aspect to using these plans, it is that you must estimate carefully what your expenses will be. If you set aside more than you will need to pay medical or dependent care expenses, you will forfeit any money left in the account as required by the IRS.

Contact the Benefits Center for a brochure that provides details of both plans and enrollment forms. Enrollment is only permitted during the Benefit Choice Enrollment Period or within 60 days of a qualifying change in family status.

Comparison of the dental plans

Both the Quality Care Dental Plan and the CompDent of Illinois managed care dental plan are administered by CompDent and any inquiries regarding claims, managed care participating dentists, etc., should be directed to (800) 999-1669.

Dental coverage is automatic for all employees (and dependents as long as they are enrolled in one of the health plans). The employer and dependent must be faxed on the same dental plan. Employees cannot enroll in the dental plan and waive the health plan or vice versa.

Benefits information by phone

Call Benefits On Call at 265-UBIC

Now you have an alternative to calling a benefits counselor if you want to verify your health plan enrollment or need to know how much life insurance you have. This information and much more is available by calling Benefits On Call almost any time, including evenings and weekends. The only time Benefits On Call is not available is 4 to 6 a.m. Monday through Saturday and 10 p.m. Saturday to 8 a.m. Sunday. All you need is a push-button telephone.

With Benefits On Call you can:
- Request a printed Personal Benefits Statement be mailed to you.
- Request claim forms and some other forms be faxed or mailed to you.
- Listen to confirmation of health and dental plan enrollments as well as how many dependents, if any, are insured.
- Find out amounts of insurance coverage under the state term life plan and accidental death and dismemberment plans.
- Get confirmation of tax-deferred retirement plan and flexible spending account enrollment as well as the percent of salary or dollar amount you authorized to be deducted monthly.
- Get answers to many benefits-related questions, such as when changes are allowed, when dependents can be added and how long they are eligible, etc.

How to use Benefits On Call

Using a push-button phone, press 265-UBIC (8422), or 5-8422 from a university phone. You will hear a welcome message and be asked to enter your Social Security number followed by the # key.

Next you will be asked to enter a four-digit personal identification number (PIN) that you can then change to a PIN of your choice to secure your record. That new PIN will be required for all future calls to Benefits On Call.

The system will then give you a menu of topics that can be accessed by pressing the appropriate number on the telephone keypad.

Once you become familiar with the system, you will be able to take shortcuts from the main menu by pressing the series of numbers given in the table below.

Benefits on Call

Shortcut from Main Menu

To bypass interim menus and go directly to an area of interest, press the numbers of a topic below at any time during the Main Menu.

Benefits Statement or Forms
Benefit statement faxed 21
Benefit statement mailed 22
Forms faxed 31
Forms mailed 32
Tax-deferred plans
403(b) enrollment 131
457 enrollment 132
Health Insurance
Health plan enrollment 111
Changing plans 411
Adding dependents 412
Current dependent coverage 413
Filing claims 415
Dental Insurance
Enrollment 112
Changing plans 411
Filing Claims 4152
Life Insurance
Employee life insurance 1211
SPO life insurance 1212
Child life insurance 1213
Accidental death insurance 122
Medical and/or Dependent Care Assistance Plans
Enrollment, contribution amount 14
Disability Coverage 123

Benefits on Call provides information only. You may not change any of your benefit options using this service.
Benefits briefs

When to contact the Benefits Center

- Change in your home address
- Change in your marital status
- Expect or have a new baby (if you want the child insured)
- An insured child marries or otherwise becomes ineligible. (See “Who’s eligible” below right.)

While on leave from the university ...

If you are on a disability, family or seasonal leave, etc., the Benefits Center will send a monthly bill to your home for any insurance premiums that are normally deducted from your paycheck. To avoid cancellation of your insurance plans, please remember the following:

1. Keep your home address current to ensure that your bill is sent to the correct address. If your address has changed, complete a new Employee Information Form. This form is available from the Benefits Center, the Academic Human Resources Office, and Personnel Services.
2. Pay your bill by the due date.
3. If you have questions, please call your benefits counselor or the person listed on the bill.

If you rent out your home because a bill was not paid, re-enrollment is possible only when you return to work and re-enrollment in some optional plans is not guaranteed. For example, re-enrollment for optional life insurance will be subject to evidence of good health and approval.

Enrolling newborn children

While enrollment of a newborn child in the health plan is guaranteed (provided the request is made within 60 days of birth), it is never automatic. The only way a new child is added to your plan is for you to contact the Benefits Center and request forms to add the child. Notifying your HMO office, obtaining precertification for delivery through the Quality Care Health Plan, or filing claims for delivery expenses do not result in a notice of birth to the Benefits Center.

If you plan to insure the newborn as your dependent, you should visit or call the Benefits Center to “pre-enroll” the child. Then you will only need to provide the Benefits Center with a copy of the birth record (supplied by the hospital) following birth and you will avoid the risk of nursery and other newborn medical expense claims being delayed or denied. You can also provide a Social Security number for the child and notify the Benefits Center when it is received. However, that number is not required in order to enroll the child.

Rules for adding dependents

Federal legislation called the Health Insurance Portability and Accountability Act (HIPAA) allows you to add dependents to your health plan without showing evidence of good health and without insurer company approval.

Eligible dependents are defined as a legal spouse, children younger than 19 or children who are full-time students up to age 23. Enrollment must be requested by May 31 and coverage will be effective July 1.

After Benefits Choice, dependents not added at employment, marriage or birth can be added without evidence of good health following a change in family status such as a spouse’s loss of other insurance.

HIPAA also affects the applicability of pre-existing condition limitations if an individual being added to the plan has “creditable coverage.” A pre-existing condition is defined as any condition for which an individual has received treatment or taken prescribed medications in the three months prior to their effective date under the plan. Then there are no benefits or limited benefits (depending upon the plan chosen) payable for that condition for the first six months of coverage. “Creditable coverage” is defined as any group or individual health coverage in effect for an individual within 63 days of becoming insured under any health plan.

What this means is that the six month pre-existing condition limitation will be reduced by the time period the individual was insured under another plan before the university plan’s effective date. Two examples:

1. A new employee comes to the university within 63 days of leaving another employer and has had continuous health insurance for the past year. That previous year of coverage completely eliminates any pre-existing condition limitation under university plans.
2. A new employee is enrolled under another plan for the past four months would be subject to the pre-existing condition limitation for only two months – the six month pre-existing period is reduced by the four months of previous coverage.

The same examples apply to dependents added at employment, during a later Beneficiary Choice or following a change in family status.

Recertify dependents in August

The state requires yearly recertification of dependents age 19 or older enrolled as students, handicapped or under the “other” category. Annual recertifications were previously processed during the Beneficiary Choice period. However, beginning July 1, the recertification period will be during August and become effective Sept. 1.

Eligible dependent children (19+)

Student: Enrolled as a full-time student (as defined by the school) at an accredited school. This dependent must be financially dependent upon the employee and eligible to be claimed as a dependent for Illinois state income tax purposes.

Handicapped: Continuously disabled from a cause originating prior to age 19, financially dependent upon the employee and eligible to be claimed as a dependent for Illinois state income tax purposes.

Other: The dependent must have been enrolled in the state health plan continuously since before Feb. 1, 1983. In this case, it is important to notify the Benefits Center if the dependent is to be claimed as a dependent for Illinois state income tax purposes by the member. Dependent life insurance is not available to persons in this category.

If the dependent does not qualify under any of these options, you must notify the Benefits Center so coverage can be terminated and the dependent can be offered the chance to continue the coverage at the employee’s own expense under the federal legislation known as COBRA, which allows for up to 36 months of continued coverage.

Benefits for part-time employees

Persons with appointments between 50 and 99 percent are eligible to participate in the group insurance plans. However, they must share in the cost of those benefits if their initial date of employment was after Jan. 1, 1980. The proportion of premium paid by employees is based on their appointment. For example, for a person with a 60 percent appointment, 60 percent of the employer contribution is paid by the university, the employee would pay through payroll deduction the other 40 percent, in addition to any amount normally deducted for an employee.

Since part-time employees must share in the cost, they have enrollment options not available to full-time employees:

- Enroll for health, dental, vision and life insurance
- Enroll in the health, dental, vision plans only
- Enroll for life insurance only
- Waive participation in all plans

Those electing to waive participation in all or some of the plans must elect and enroll as “new” during any Beneficiary Choice Enrollment Period. Each year during Beneficiary Choice, the Benefits Center notifies part-time employees of their option to enroll. Enrollment is automatic without regard to health conditions. It would, however, be subject to any pre-existing condition limitation applicable to the selected health plan.

Part-time employees electing to waive coverage in order to be covered as the dependent of another state/ university employee must waive all plans. For example, the option to enroll for life insurance and waive health and dental is not available.

Changing health plans? Pre-existing conditions covered immediately

If you have been employed and enrolled in one of the health plans for at least six months, the pre-existing condition limitation will not apply when you are simply switching plans. This means that if you or an insured family member are being treated for a health condition, covered expenses incurred due to that condition will be eligible for benefits beginning on the first day of coverage under the new plan.

Continuing coverage under ‘COBRA’

Under the Consolidated Omnibus Budget Reconciliation Act, commonly called the “COBRA option,” coverage can be continued:

- For up to 18 months for employees and insured dependents – the Benefits Center is notified of employment terminations (other than retirement) by the appropriate human resources office.
- For up to 36 months by a divorced spouse or ineligible child – it is the employee’s responsibility to notify the Benefits Center within 60 days of a dependent becoming ineligible. Children become ineligible when they marry regardless of age, when they reach age 19, or age 23 if a full-time student.

The Benefits Center then notifies the state’s Department of Central Management Services (CMS). That office sends details about the cost and length of continuation available to the current address on file for the employee. To ensure continuation information is received, it is very important to notify the Benefits Center if it should be sent to an address other than the home address currently on file.

Continuation of coverage is guaranteed provided it is elected within 60 days from the date the election form is received. If elected, the premium due will be retroactive to the date of coverage termination. More information about the continuation option can be found in the Member Benefits Hand- book. Rates for continuation coverage can be obtained from the Benefits Center.

Who’s eligible for benefits?

For employees, the criteria for eligibility are as follows:

- Permanent appointment of 50 percent or more
- Temporary appointment of 50 percent or more for at least nine continuous months
- Eligible to participate in the State Universities Retirement System
- The Illinois State Employees Group Insurance Act requires that all employees who are enrolled in the health, dental, vision and life insurance plans. Part-time (50 to 99 percent) employees may elect to waive all coverages, enroll for health, dental and vision only, life only, or both.

Eligible part-time employees are required to pay a share of the normally employer-paid premiums proportionate to their appointment time.

The Group Insurance Act also defines eligible dependents as:

- Legal spouse
- Unmarried child from birth to age 19, including a natural or adopted child of a stepchild, who lives with the employee in a parent-child relationship
- Unmarried child age 19-23 who is a full-time student in an accredited school and is financially dependent upon the employee
- Unmarried child age 19 and older who has been continuously mentally or physically handicapped with the cause originating prior to age 19 and is financially dependent
- Non-student child age 19 and older who has been continuously enrolled as a dependent prior to Feb. 11, 1983, and continues to be financially dependent upon the employee

Dependants not added at the time they first become eligible – within 10 days of an employee’s first day of work – may only apply during the annual...
Benefits briefs (Continued from page 6)

benefit choice enrollment period or within 60 days of a marriage, birth, adoption or some other qualified change in family status.

Make your change by phone (800) 572-2390

A gain this year you have the option to change your health or dental plan by phone. CMS’ telephone enrollment system can be used until midnight, May 31 – 24 hours a day, seven days a week, from anywhere in the continental United States. Before making any changes by phone, please check with your dependents to ensure they qualify for the change. For example, employees with dependent coverage will be able to use the telephone enrollment system only if their dependents’ Social Security numbers are already included in their insurance record. The telephone enrollment system also cannot be used to add dependents for coverage.

If you are interested in changing your enrollment by phone, be sure to read Pages 3 – 8 of the Benefit Choice Options booklet. There you will find complete instructions and a worksheet that helps ensure you have all the information required prior to calling. Please note that when you use the system to make a change, your new elections are not complete until you hear “Your change (election) has been recorded.” You can call back immediately and hear that your change has been recorded by the telephone enrollment system. CMS will send a verification of your change to the Benefits Center and it will be forwarded to you.

Want to quit smoking?

Members and their dependents are eligible to receive up to a $50 rebate toward the cost of an approved smoking cessation program. This rebate is limited to one per year and is available upon completion of the smoking cessation program. Hypnisis (performed by a professional other than a medical doctor) and acupuncture are not eligible under this program. To receive reimbursement, you must submit:

- Receipt of payment for the program.
- Program certificate verifying the number of sessions and completion of the program.
- Member’s name, Social Security number, and telephone number

Send the information to:
Smoking Cessation Program
CMS/Group Insurance Division
Room 600, Stratton Office Building
Springfield, IL 62706

Adoption benefit program

Recognizing adoption as a meaningful and viable way to build a family, the State of Illinois has implemented an Adoption Benefit Program to assist state of Illinois employees who adopt a child. To encourage adoption, especially of children who traditionally wait longer for families, the program can apply for adoption benefits. The following example, which assumes an annual salary of $50,000, may be helpful:

- $100,000 Total life insurance (basic $50,000 plus $100,000 optional)
- $50,000 Less tax-free coverage
- $48 Federal premium per $1,000 (age 50 at end of calendar year)
- $43 Optional premium deduction (age 50, $43 per $1,000)
- $5.00 Taxable Benefit

What is the excess life valuation? It’s a calculation required by the federal government when an employee’s amount of life insurance under the state plan exceeds $50,000 – the maximum amount for which premiums can be paid tax free. The dollar amount shown in the “This Pay” column on the earnings statement reflects the difference between the federal premium rate and the state’s actual premium rate, which must be reported as a taxable benefit.

The following example, which assumes an annual salary of $50,000, may be helpful:

- $150,000 Total life insurance
- $50,000 life insurance under the state plan
- $100,000 and the person making the request.

Comparison of new retirement plans

Traditional or Portable Benefit packages

If you...

- Want your fixed retirement payments to be unaffected by the financial markets.
- Currently already have several years of credited service within the system.
- Plan to stay with UI for many years.
- Prefer no involvement with your account.

Advantages

- SURS bears investment risk.
- The retirement benefit is known.
- For members with many years of service, the defined benefit formula might provide a larger benefit.
- SURS hires and supervises professional investment managers.

Disadvantages

- For younger members, it takes many years of service to build a big benefit.
- Members with short service, or those who expect to leave their job soon, will not earn a large benefit.
- Members have no control over account investment decisions.

Self-Managed Plan

If You...

- Want investment control.
- Are a younger employee.
- Do not plan to spend your entire career at UI.

Advantages

- Member benefit if investment performance is good.
- More portable – members can transfer balances to other defined contribution plans should they change employers.
- Members have more control over investment decisions.

Disadvantages

- Members bear investment risk and so must actively monitor their investments.
- The benefit is not known until retirement and depends on investment results.
- Older members have fewer years before retirement to invest in their accounts.

- Costs are greater because of the need to track each member's elections, election changes and investment results.

What is “TXBL BEN”? Many employees may have noted this entry in the deductions area of their earnings statement. It’s short for Taxable Benefit and generally only includes the excess life insurance valuation, although it could include other items in a very limited number of cases.

significant members of the employee’s household and all employees of allied agencies are eligible for the program’s services. More information is available by calling 244-5312.

Changes locked in until July ’99

The Irrevocability Rule of the Internal Revenue Service (see pages 2-4, current state of Illinois Benefits Handbook) requires that any changes made during Benefit Choice be irrevocable for the plan year (July 1 through June 30) for all tax exempt programs. Health, dental and life insurance (up to $50,000 in coverage) as well as contributions to the Medical Care Assistance and Dependent Care Assistance plans are included. Changes at other times of the year cannot be made unless you experience one of the special enrollment events or you have a qualified change in family status such as:

- Marriage or divorce
- Birth or adoption of a child
- Child becomes ineligible because he/she is no longer dependent or has reached the limiting age
- Death of a dependent
- Spouse loses or gains health insurance through employment
- Employee begins or ends a period of no salary
- Employee reaches the limiting age
- For any reason not covered above.

For a complete listing of these qualified family status changes and special enrollment events, see Page 4 of the current state of Illinois Benefits Handbook.

Premium for coverage above $50,000 is not tax-exempt and coverage above that amount can be changed at any time.
**Premium costs**

The Quality Care Health Plan premium for dependents continues to be "frozen" for this year and will remain the same for next year as well. HMO rate changes up or down vary depending upon the HMO and whether coverage is for only one dependent or two or more dependents.

The share of premium based on salary that all employees are required to pay for their own health insurance will increase by $5 at all salary levels effective July 1. Salaries as of April 1 are used to determine the appropriate employee share but any change in that amount will not appear until the July payrolls.

Premiums for the Quality Care Dental Plan will remain the same for the new year and there will continue to be no premium charge to employees enrolled in the managed care dental plan.

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**Salary-based employee contributions for health plans**

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<td><strong>Employee only</strong></td>
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<td>Health Plans</td>
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<td>Quality Care</td>
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<td>Health Alliance HMO</td>
<td>See salary-based employee contributions above.</td>
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<td>PersonalCare HMO</td>
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<td><strong>Dental Plans</strong></td>
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<td>Managed Care</td>
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*All the following dependent premium amounts exclude the “salary-based employee contributions” listed above. To calculate your total monthly premium, add the appropriate salary-based employee contribution amount to the dependent premium amount.

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**Plan Administrators**

For more information, contact the following plan administrators. Plans and administrators may change, so watch for mailings updating your benefits and check the Annual Benefit Choice Options booklet for the most current information.

**Quality Care plans**

**Quality Care Health Plan**

- Medical Plan Administrator: UNICARE
  - Group Number 28455
  - State of Illinois
  - P.O. Box 5025
  - Bolingbrook, IL 60440-5025
  - (888) 209-7950 (nationwide)
  - TDD: (888) 209-7953

- Medical Precertification and Medical Case Management Administrator:
  - Intrafocus
  - (800) 327-7443
  - TTY: (800) 855-2880 (National Relay Service)

**Medical Assistance Program (MAP)**

- Mental Health and Substance Abuse Treatment Plan Administrator:
  - Green Spring of Illinois
  - P.O. Box 909782
  - Chicago, IL 60690
  - (800) 513-2611
  - TDD: (800) 526-0844 (Illinois Relay Center)

**Quality Care Dental Plan**

- Indemnity Dental Plan Administrator:
  - Compdent Inc., Group Number 950
  - P.O. Box 4677
  - Chicago, IL 60680-4677
  - (800) 999-1669
  - TDD: (312) 829-1298

- HMOs
  - Health Alliance HMO
    - (800) 851-3379
    - TDD: (217) 337-8137
    - Personal Care
      - (800) 431-1211
      - TDD: (217) 366-5551

- Managed Care Dental plan
  - Managed Care Dental Plan Administrator:
    - Comp Dent of Illinois
      - P.O. Box 4677
      - Chicago, IL 60680-4677
      - (800) 999-1669
      - TDD: (312) 829-1298

**Vision plan**

- Vision Plan Administrator:
  - Vision Service Plan (VSP)
    - 222 South Riverside Plaza, Suite 2210
    - Chicago, IL 60606
    - (800) 877-7195
    - TDD: (800) 428-4833

**Flexible Spending Accounts**

- FSA Program Administration:
  - FSA Unit
    - CMS/Group Insurance Division
      - Room 619, Straton Office Building
      - Springfield, IL 62706
      - (800) 442-1300 or (217) 782-2548
      - TDD: (800) 526-0844

- Claims Adjudication Service:
  - Fringe Benefits Management Co. (FBMC)
    - (800) 342-8017

**Life insurance, smoking cessation or adoption programs**

- CMS/Group Insurance Division
  - Room 600, Straton Office Building
  - Springfield, IL 62706
  - (800) 442-1300 or (217) 782-2548
  - TDD: (800) 526-0844

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*Your Benefits* is printed annually for faculty and staff members of the University of Illinois at Urbana-Champaign. Every effort has been made to report the information included in this paper accurately. However, in the event of any discrepancy, the legal documents, policies or contracts pertaining to the various pay and benefits would prevail. This paper does not constitute such a legal document. Save this document for future reference.